DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/02/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475032	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMONT VETERANS HOME	325 NORTH STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 11/8/11, and completed on 11/17/11. There were regulatory violations identified as a result.	F 000	Please note that the filing of this plan of correction does not constitute any admission as to any of the alleged violations set forth in this Statement of Deficiency. The POC is being filed as evidence of the Facility's continued compliance with all applicable laws.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to assure that resident transfer equipment was maintained in proper working condition. Findings include: Per review on 11/8/11, a letter received at the Division of Licensing and Protection written 9/30/11 stated that some of the mechanical lifts being used to transfer residents were not working properly, a discharged battery making it inoperable in either direction. In another letter dated on 10/4/11, it was stated that the lift was being operated without a safety strap that secures the residents legs to the lift machine. Per observation on 11/8/11 at 1:50 PM, during a transfer of Resident #1, this surveyor observed the battery meter on the lift read approximately ¾ full charge on it, and witnessed that the lift did not have the strength to operate properly to either lift the resident or lower him/her back down to the chair. The resident stated that this was a situation that had occurred several times before with more	F 253	**F253** Corrective Action: The facility ensures all mechanical lifts are maintained in proper working condition Other Residents: All Residents who require the use of a mechanical lift for transfers are at risk. Systemic Changes: 1) All mechanical lift batteries will be replaced yearly and PRN and their proper functioning will be monitoring during the monthly Preventative Maintenance. (Attachment A1). 2) All Staff will be re-educated on the facility's policy and procedure for Maintenance Requests. (Attachment A2) Monitoring: 1) The Maintenance Director or designee will conduct monthly audits, x 3 months, of all Preventative Maintenance of the facility's mechanical lifts to ensure all repairs have been completed. (Attachment A3)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa A Jackson — TITLE: Administrator — (X6) DATE: 12/8/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 than one lift. Staff was able to use the emergency release button to lower the resident to the chair. Per interview with the staff conducting the transfer, they stated that they had reported the weak performance of the lift to maintenance verbally, however had not put in a written work order regarding this matter. They also confirmed at this time that they had to use the lift without the leg safety strap at times in the past when the plastic buckle was broken that secured the resident's legs to the lift. Per interview on 11/8/11 at 2:15 PM, the maintenance personnel who was identified as the one who maintains the mechanical lifts, stated that he had started a monthly preventative maintenance program on October 26, 2011 to examine all the lifts in the building for proper performance, and showed me the checklist used to inspect the machines, not only for function, but also for proper storage and cleaning of the equipment, and acknowledged that there had been some problems with the lift not operating at full strength sometimes. Per telephone interview on 11/17/11 at 11:10 AM, the Director of Maintenance stated that the policy to alert maintenance of a problem that needs their attention is to write a work order in a book that is available at each unit's nursing station. Maintenance checks the books at least daily and usually more than daily, and also have followed up on items that were only relayed verbally to them. The monthly preventative maintenance program was started in October 2011, however before that time the mechanical lifts were maintained when staff reported a problem, and not routinely examined on a monthly basis.	F 253	2) The Maintenance Director or designee will conduct 3 weekly audits, x 60 days, of Maintenance requests to ensure maintenance requests have been responded to. (Attachment A4) Audit results will be reported at the bimonthly QA meeting. Compliance Date: December 14, 2011 F 253 POC accepted Karen Campos RN 12/15/11	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 2 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for one resident regarding a specialized treatment for edema. (Resident #1) Findings include: Per record review on 11/8/11, Resident #1 was admitted with a medical condition that requires a specialized dressing for compression to treat a type of edema. The facility arranged for the Physical Therapist who had been treating the resident before the nursing home admission to come to the facility and instruct staff on the proper method of dressing the leg to reduce edema. On 6/28/11, the therapist video taped the procedure with the resident's permission, as well as left detailed written instruction for staff to perform the dressing change properly. Per interview with Resident #1 on 11/8/11, three nurses were present at the training session with one of them holding the camera while the physical therapist demonstrated the procedure. In the opinion of the resident, the three nurses are all competent in the dressing procedure, and the resident accepts care from these three nurses	F 309	**F309** **Corrective Action:** Per MD's orders Resident #1 edema wraps have been discontinued. **Other Residents:** All Residents with orders for specialized edema wraps are at risk. **Systemic Changes:** 1) The facility staff have been educated on the facility Refusals of Treatments and Medications Policy. (Attachment B1) 2) Prior to the start of edema wraps for any facility resident. The facility will ensure an adequate amount of staff have been trained in the treatment as ordered. 3) The Clinical Care Coordinators will conduct weekly audits of TARs house wide to ensure that reasons and patterns of refusals are addressed with the Residents and interventions documented to continue indefinitely. (Attachment B2) **Monitoring:** 1) The Clinical Care Coordinator will conduct 3 weekly audits x 60 days of Resident #1's TAR to ensure that reasons and patterns of refusals are addressed with the Resident and interventions	

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F 309	Continued From page 3 who received training. On occasions where the nurse on duty had not been trained in the proper procedure, although the nurse was willing to attempt the dressing change, the resident was not comfortable with un-trained staff performing the procedure and would refuse to allow them to, due to the potential for tissue damage from incorrect application. Per review of the nurses' notes and treatment sheets, there were many circled initials of staff on the documentation, indicating that the dressing had not been applied, and notes on the reverse side of the sheets explaining the reason were a combination of supplies not available (sleeve not dry or in laundry), or resident refusal. Resident #1 kept a daily log of whether the dressing was changed or not, and when comparing this log with the treatment sheet documentation there was only one day where the documentation did not coincide with the log kept by the resident. In October 2011 for example, the treatment sheet documentation showed that the dressing was not applied on 10 days out of the 31 days in October (Oct. 1, 3, 4, 5, 7, 8, 12, 14, 23, and 28) and two blank spaces with no initials on the treatment sheet on October 19 and 22, 2011. This was also the case in September, where at least 12 out of 30 days had circled initials on the treatment sheet to indicate the dressing had not been applied. Per interview on 11/8/11 at 3:35 PM, a nurse who is trained to complete the dressing change confirmed that there is not always a staff nurse who has been trained in the procedure available to provide the care, that the resident's leg responds well with decreased edema when it wrapped correctly overnight; and that they can see the increased edema when the dressing was.	F 309	documented. (Attachment B3) 2) The DNS or designee will conduct weekly audits, x 60 days, of all new orders for edema wraps to ensure staff education has taken place and to ensure an adequate amount of staff have received training on the application of the wraps.(Attachment B4) 3) The DNS or designee will conduct 1 weekly audit x60 days of Resident #1's TAR and dressing supplies to ensure compliance. (Attachment B5) Monitoring audit results will be reported to bimonthly QA meetings. **Compliance Date:** December 14, 2011 F309 POC accepted Karen Campo RN ~~25673~~ 12/15/11	

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F 309	Continued From page 4 not applied the night before.	F 309		